FINANCIAL POLICY AND CONSENT FOR SERVICES

Thank you for choosing Resh Family Dentistry for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. As a condition of treatment, written financial arrangements are made in advance to ensure you understand your financial obligation. For your convenience, we accept cash, credit cards, debit cards and flex spending cards. We also have flexible payment and dental savings plans available.

INSURANCE: For those patients with dental insurance, we're happy to submit your dental claims and accept payment from your insurance company. Your insurance contract exists solely between you and your insurance carrier. We cannot be responsible for the limitations and exclusion determined by your participating insurance plan. If your insurance carrier downgrades your services or pays a lesser amount according to your coverage then you, the patient will be responsible for the remaining balance due within thirty (30) days of receiving your explanation of benefits from your insurance provider.

TREATMENT PLANS: A treatment plan estimate is a good faith attempt to predict the cost of treatment. As treatment progresses, your dentist may determine in consultation that different or additional treatment is necessary and your financial responsibility may change. Treatment estimates can only be extended for a period of six (6) months from the date treatment was recommended.

AUTHORIZATIONS

☐ **By checking this box:**

- I authorize Resh Family Dentistry to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.
- I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Resh Family Dentistry.
- I grant permission to Resh Family Dentistry to: *(check all that apply)*
  ☐**telephone** ☐**email** ☐**text** me to discuss my account or treatment.
- I understand that cancellations must be at least 24-hours in advance of a scheduled appointment. The charge for single missed appointments or appointments not cancelled within 24-hours will be charged at a rate of $50 for each hour scheduled.
- I understand that interest of 8% per month will be added on unpaid balances over sixty (60) days; accounts over ninety (90) days delinquent will be sent to a collection agency and a collection fee of 35% of the balance will be charged to my account; a $50 charge will be added to my account for a returned check.
- I understand that it's my responsibility to notify my dentist within thirty (30) days of service if there is a problem. I also understand the through this notification, my dentist will act on my behalf to attempt to correct the problem or provide a referral to another health care practitioner. Any concerns past thirty (30) days will be the responsibility of the patient and any services provided will be an additional cost to the patient.
- I accept and agree that there are risk and limitations to all procedures. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee and/or assurance has been made by anyone regarding dental treatment that I have requested and authorized.

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION. I acknowledge that all my questions have been answered to my satisfaction. You have the right to accept or deny treatment before it is performed. The fee(s) for these services have been explained to me and I accept them as satisfactory. I understand the insurance estimate is not a guarantee of payment and that I am responsible for any difference in payment. By signing this form, I am freely giving my consent to authorize Resh Family Dentistry including the dentists, hygienists, and administration to use and/or prescribe anesthetic agents and/or medications. Resh Family Dentistry reserves the right to change or cancel these terms and conditions at any time.

Patient Printed Name	Signature of Patient (Parent or Guardian)	Date
Witness Signature	Date	